Amanda Holden Counseling
North Portland Growth Place
7415 North Oatman Ave

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INTAKE QUESTIONNAIRE

GENERAL

Today's Date: _____

Name _____ Date of Birth _____

Address _____ City _____State _____ Zip _____

Phone - Day: _____ Evening: _____ Cell: _____

Is it okay to leave message on any of the above numbers? _____

How do you describe your race and/or ethnicity? _____

What is your gender? _____

What are your gender pronouns (they, he, she, ze, etc.)? _____

What is your current relationship status?
Partnered _____ Separated _____ Divorced _____ Married _____ Widowed _____

How long have you been together with your significant other? _____

Concerning sexual/romantic orientation, how do you self-identify? _____

How did you find my practice or who referred you to counseling with me? _____

What cultural beliefs and/or traditions are especially important to you that you would like me to know about?_____
_____

Are you currently attending school or a training program? _____ If yes, please describe: _____
_____
_____

Please check which one describes your current situation best:

_____ Employed _____ Unemployed: looking for work _____ Unemployed: in school/training

_____ Unemployed: not looking/not in school/training _____ Retired

_____ Employed part-time/part-time stay-at-home parent _____ Full-time stay-at-home parent

If applicable, what is your profession and/or area of study or professional training? _____

MENTAL HEALTH

Have you ever received a mental health diagnosis? _____ If yes, please provide details (diagnosis, provider, date) _____

Have you been in individual counseling before? □ Yes □ No
If so, give a brief summary of concerns you addressed.

Has a physician prescribed mental health/psychiatric medications for you to be taking currently? _____

Current mental health medications: _____

Have you ever been hospitalized for mental health reasons? _____

Have you ever considered suicide? When was the last time you thought about suicide? _____

MEDICAL AND SUBSTANCE USE

Who is your primary care doctor? _____ Doctor/prescriber's phone # _____

Emergency contact: _____ Phone #: _____ Relationship to you: _____

Are you receiving any other health care (nutrition, chiropractic, massage, naturopathic)? _____

If so, where and from whom? _____
Do you have current medical concerns of which you believe I should be aware? If so, please explain:

Current medications/supplements	Reason	Prescriber (if applicable)

Do you use tobacco products? _ If yes, how much and how often? _____

How many drinks of alcohol do you consume each week? _____

Have you used recreational drugs (including marijuana, misuse of prescription pills) in the past year? _____

If yes, please specify which drug(s) and how often _____

Have you ever received treatment for substance abuse or dependency? _____ If yes, please describe: _____

FAMILY HISTORY

Please complete the following information about your family:

Name: Please circle those adults who raised you	Age	How would you describe your relationship with this person when you were a young child? Now?	Is this person living or deceased?	Current or past substance abuse problems?	Current or past mental health problems?
Parent					
Parent					
Parent					
Step-Parent					
Step-Parent					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Grandparent					
Grandparent					
Grandparent					

When you were a child and feeling upset or hurt, what would you do?_____
_____

When a parent or caregiver was feeling upset with you, what would they do? _____
_____
_____
_____
_____

In what ways do you believe your early childhood experiences with your parents/guardians have affected you in relationship to your partner?_____
_____
_____
_____

Are there specific events in your childhood you believe had a profound impact on the person you are today?_____
_____

Do you have any children? _____ If yes, please provide the following information about the children in your family:

Name: Please indicate if biological or step-child	Age	How would you describe this child?	Is your child living or deceased?	Substance abuse problems?	Mental health problems?
Child					
Child					
Child					
Child					
Child					
Child					

Have you ever had a miscarriage, stillbirth, or abortion you'd like to me to know about? _____ If yes, what would you like me to know about the result on you now and your current relationships? _____
_____
_____

RELATIONSHIP

Name of partner:_____
Partner's date of birth:_____

1. Have you and your partner engaged in prior couples' counseling? □ Yes □ No

If yes, when: _____ Where: _____
With whom: _____ Length of time in counseling: _____
Concerns addressed: _____
_____

2. What was the outcome? Please check one and provide brief summary.
□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse
_____
_____

3. Rank order the top three goals that you have in your relationship with your partner (1 being the most important):

1. _____
2. _____
3. _____

4. What have you already done to accomplish these goals? _____
_____

5. As you think about the primary reason that brings you here, how would you rate your overall level of concern at this point in time?

□ No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concerns

6. On a scale of 1 to 10, what is your level of commitment to this relationship (1 = not at all, 10 = extremely). ____

7. Have either of you threatened to separate or divorce (if married) as a result of the current relationship challenges?

If yes, who? ___Me ___Partner ___Both of us

8. Do you perceive that either you or your partner has withdrawn from the relationship?

If yes, who has withdrawn? ___Me ___Partner ___Both of us

Thank you for completing this. Please bring this with you during your first appointment and **please note you may be asked to talk about your answers in sessions**.

PROFESSIONAL DISCLOSURE STATEMENT

Amanda Holden, LPC, CADC-I
North Portland Growth Place
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My goal for you as my client is to provide a safe, supportive environment in which you can move toward greater health and healing. I can help you make desired changes as well as move toward an improved quality of life, self-respect, self-discovery, and healthier relationships. I believe that everyone, no matter their life experiences thus far, has the capacity to do this. To assist clients, I employ tenets of therapy modalities such as Motivational Interviewing, Cognitive Behavioral Therapy, Narrative Therapy, Client-Centered Therapy and Reality Therapy. I hold a master's degree in Marriage and Family Therapy from George Fox University.

As a licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my professional counseling license, I am required to participate in annual continuing education in subjects relevant to this profession and am permitted to substitute professional supervision for part of this requirement. I also regularly participate in consultation with professional colleagues in order to provide the most helpful, ethical counseling services possible. Please ask if you have questions about this.

I have also met the necessary training and work experience requirements to be designated a Certified Alcohol and Drug Counselor (CADC-I). As a CADC-I with the Addiction Counselor Certification Board of Oregon, I abide its Code of Ethics as well.
My fee per 50-minute counseling session is $130. If you cannot afford this, we can discuss a sliding scale fee.
As a client of a licensee with the OBLPCT, you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be informed that, by law, health care information pertaining to you may be released only with your written consent.
- To be assured of privacy and confidentiality while receiving services as defined by rule and law including, but not limited to, the following exceptions:
- When the client or those persons legally responsible for the affairs of the client give consent to the disclosure;
- When the communication reveals the intent to commit a crime or harmful act;
- Reporting imminent danger to the client or others;
- Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
- Providing information concerning licensee case consultation or supervision; and
- Defending claims brought by client against licensee;
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

You may contact the Oregon Board of Licensed Professional Counselors and Therapists at 3218 Pringle Road SE #120, Salem, OR 97302-6312. Telephone: (503) 378-5499.
Email: lpct.board@oregon.gov. Website: www.oregon.gov/OBLPCT
By signing below, I acknowledge that I have read this statement and understand my rights as a client. I also understand that counseling can be difficult and challenging.

Client Name (Print)	Client Signature	Date

Amanda Holden, LPC, CADC-I	Date

GENERAL INFORMED CONSENT

It is important at the beginning of our professional therapeutic relationship that you understand both the nature and limitations of the relationship. The therapy relationship is a professional and confidential relationship. What is revealed in the setting is generally protected by professional and ethical standards, to the extent that, with a few important exceptions, all material you disclose is confidential and cannot be released without your written consent. However, there are certain circumstances under which I am ethically or legally required to disclose information. I am required to disclose information in the following circumstances:

- If there is a reasonable belief child abuse has occurred.
- If there is a reasonable belief elder abuse has occurred.
- If there is a reasonable belief abuse of an adult with developmental disabilities has occurred.
- If you make a threat to harm a third party.
- If you pose a serious risk to yourself or others.

You should realize that in therapy, I'll endeavor to provide you with the best care I can. To facilitate this, please advise me of your physical and emotional conditions to the best of your ability. Therapy can be exciting and helpful and often it can feel hard or stressful. Please let me know if you are struggling or need help and I will do what I can to put you at ease. Its important to know sometimes feeling bad is a precursor to feeling better!

Please do not use email communication for therapeutic issues, emergencies and crises. Email communication with me is only for the purposes of providing general information about counseling or scheduling. If your email contains other information, questions or concerns, I will print out the email and bring it to our next session together for discussion. Also, I only respond to emails and phone calls on Mondays, Wednesdays, Fridays, Saturdays, and Sundays excluding major US holidays. Please do not email in an emergency. If you are in immediate danger, please call 911 or the crisis line at 503.988.4888.

As a therapist, I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to: Untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, the client's needs are outside the therapist's scope of competence, or the client is not making adequate progress in therapy. The client has the right to terminate therapy at his/her/their discretion. Upon either person's decision to terminate therapy, the therapist will generally recommend that the client participate in at least one or more terminations sessions. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals.

As this is a business for me, it is important that you let me know with more than 24 hours' notice if you cannot make an appointment. I**f you fail to cancel a scheduled appointment with fewer than 24 hours notice, I cannot use this time for another client and you will be billed the full fee for your missed appointment.** In order to do this, it is necessary for me to get your credit card information.

Name as listed on card: _____

Card #: _____ Expiration date: _____

3 digit CCV code: _____ Zip code: _____

I have read the above information and understand what it says. I have been given a personal disclosure statement and an Informed Consent form.
To the extent that I have any questions, I have asked them of my therapist before signing this consent.

Date: _____ Client Signature: _____ Date of Birth: _____

COUPLES' THERAPY INFORMED CONSENT

It is important to understand as you enter couples' therapy that my focus for treatment is on the preservation and enhancement of the relationship.
With this in mind, when a couple begins therapy to address their relationship with one another, the couple is treated as the client unit. In order for me to preserve my neutral position in the therapeutic relationship, please note the following.

- All sessions will occur with both parties present and each session will begin only once both parties are present.

- All communication that is shared with me, regardless of format or means, will be open to both in the relationship.

- In order for me to provide effective couples' therapy, I will not keep secrets between members of the client unit. As an example, I will always copy the other partner when responding to email communication from one member of the couple.

- I will not provide individual therapy for either parties involved in couples' therapy. If only one partner shows up for a session, I will not conduct an individual session during that time and **the full session fee will be charged.** I understand this can be a difficult situation if it arises, but it is of the utmost importance for me to remain objective and neutral in my therapeutic relationship with both members of the couple.

By entering couples' therapy, you understand and accept that working toward positive change in a relationship often involves experiencing difficult or painful emotions, and engaging uncomfortable and new behaviors in order to reach therapeutic goals. It is also important to understand that as one or both of you begin making changes, this will impact not only your partner, but often your friends and family dynamics. These changes can have both positive and negative effects on your relationships with others. By signing below, you agree to evaluate potential effects of such changes before making them.

I have read the above information and understand what it says. To the extent that I have any questions, I have asked them of my therapist before signing this consent.

_____

Client Signature Date

_____

Client Signature Date

_____

Amanda Holden, LPC, CADC-I Date

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION (PHI) BY NON-SECURE MEANS

I, _____ AUTHORIZE: _____
(name of client) (name of clinician)

_____ _____
(client's email address) (street address)

_____

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

O Information related to the scheduling of meetings or other appointments

O Information related to billing and payment

O Completed forms, including forms that may contain sensitive, confidential information

O Information related to resources and referrals

O Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

O Unsecured email.

TERMINATION

O This authorization will terminate _____ days after the date listed below.

OR

O This authorization will terminate when the following event occurs: _____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____

Client Name

_____

Client Signature Date

_____

Amanda Holden, LPC, CADC-I Date

ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically using a payment card through Square.

Please Be Aware of the Following:
I have a duty to uphold your confidentiality and thus wish to make sure that your use of the above payment service is done as securely and privately as possible.

After using Square to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include my business name, and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. I am unable to control this in many cases, and may not be able to control to what email address or phone number your receipt is sent.

Before using Square to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

In addition to these possible emails or text messages, payments made by credit card may appear on your credit card statement as being made to Amanda Holden Counseling. Please consider who might have access to your statements before making payments by credit card.

I have read this disclosure and have had the opportunity to ask questions regarding this information. I consent to the use of electronic payment and automatic receipt.

_____

Client Name

_____

Client Signature Date

_____

Amanda Holden, LPC, CADC-I Date